471-000-506 Nebraska Medicaid Practitioner Fee Schedule for Dental Services

Nebraska Medicaid payment is the lower of the fee schedule allowable or the provider's submitted charge(s). The provider's submitted charge(s) must reflect their charge to the general public. Current Dental Terminology, (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

*"BR" (By Report) – Paid at "reasonable charge" based on the service and circumstances. A complete description of the service (and additional documentation, if applicable) is required for review. The provider's submitted charge must reflect their charge to the general public.

*FEE DETERMINED BY TREATMENT PLAN – Paid at Medicaid prior authorized amount based on the services authorized. A complete description of the services/treatment to be provided is required for prior authorization review. The provider's submitted charge on the prior authorization request must reflect their charge to the general public.

*PA (Prior Authorization) – Certain service require prior authorization.

*Please refer to description, coverage criteria/limitations for certain dental procedure codes.

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D0120	periodic oral evaluation	$21.20	No	Age 20 & Younger: Routine periodic oral evaluation are covered every 6 months Can be seen more frequently if determined necessary by treating dentist. Age 21 & Older: Routine periodic oral evaluation are covered 1 time every 12 months. Age 21 & Older with Special Needs: Routine periodic oral evaluation are covered at the frequency determined appropriate by the treating dentist. A client with special needs is a client who is unable to care for their mouth properly on their own because of a disabling condition or a pregnant woman.
D0140	limited oral evaluation – problem focused	$21.44	No	An evaluation limited to a specific oral health problem or complaint. Report additional diagnostic procedures separately.

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
				Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.
D0145	oral evaluation for a patient under 3 years of age & counseling with primary caregiver	$34.14	No	
D0150	comprehensive oral evaluation – new or established patient	$20.88	No	Note - All Clients Oral evaluations are covered for new patients, emergency treatment, second opinions and specialists.
D0160	detailed and extensive oral evaluation – problem focused, by report	$27.00	No	
D0170	re-evaluation – limited, problem focused (established patient; not post-operative visit	$16.00	No	
D0180	comprehensive periodontal evaluation – new or established patient	$27.00	No	
D0210	intraoral – complete series of radiographic images(including bitewings)	$45.00	No	Maximum payment of $45.00 per date of service for any combination of codes D0210 – D0330.
D0220	intraoral – periapical first radiographic image	$6.00	No	
D0230	intraoral – periapical each additional radiographic image	$5.00	No	
D0240	intraoral – occlusal radiographic (2 ¼ x 3 ¼ size)	$7.00	No	D0240 occlusal film is 2 ¼ x 3 ¼ size.
D0270	bitewing – single radiographic image	$9.00	No	Bitewings – maximum of 4 per date of service.
D0272	bitewings – two radiographic images	$13.00	No	Intraoral – complete series – covered every three years
D0273	bitewings – three radiographic images	$15.00	No	
D0274	bitewings – four radiographic images	$19.00	No	
D0330	panoramic radiographic image	$36.00	No	Panoramic film – covered every 3 years on a routine basis. Covered more frequently if necessary for treatment.

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D0340 D0470	cephalometric radiographic image diagnostic casts	$62.00 $46.00	No No	Covered for clients age 20 and younger to diagnosis if treating dentist believes through visual exam that the client may qualify for Medicaid coverage of orthodontic treatment (see 471 NAC 6-005 page 11 of 14)
D1110	prophylaxis – adult (age 14 and older)	$31.00	No	Age 14 through Age 20: Covered at the frequency determined appropriate by the treating dentist with a 6-month prophylaxis considered the standard BILL ON CODE D1110. Age 21 & Older: Covered one time per year. BILL ON CODE D1110 Age 21 & Older with Special Needs: Covered at the frequency determined appropriate by the treating dentist. A client with special needs is a client who is unable to care for their mouth properly on their own because of a disabling condition or a pregnant woman.
D1120	prophylaxis – child (age 13 and younger)	$22.00	No	Age 13 & Younger: Covered at the frequency determined appropriate by the treating dentist with a 6 month prophylaxis considered the standard. BILL ON CODE D1120.
D1206 D1208	Topical application of fluoride varnish; Topical application of fluoride	$17.15 $17.27	No No	
D1351	sealant – per tooth	$23.00	No	Covered on permanent and primary teeth, children and adults. A re-seal is not covered more often than every 2 years.
D1510 D1515 D1550 D1555	space maintainer – fixed unilateral space maintainer – fixed – bilateral recementation of space maintainer removal of fixed space maintainer	$110.00 $190.00 $21.00 $21.00	No No No No	Covered for clients age 20 and younger.

RESTORATIVE Operative dentistry fee includes local anesthetic, bases, or insulation and other procedures necessary to complete the case. Pins are billed separately. Maximum fee per tooth for any combination of amalgam or resin restoration procedure codes. The maximum fee is equal to the Medicaid fee for a 4 or more surface restoration.

Full labial veneers for cosmetic purposes are not covered. Documentation of carious lesions must be present.

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
Amalgam Restorations:				
D2140	amalgam – one surface, primary	$50.00	No	Primary teeth A – T
D2150	amalgam – two surfaces, primary	$59.00	No	
D2160	amalgam – three surfaces, primary	$71.00	No	
D2161	amalgam – four or more surfaces, primary	$71.00	No	
D2140	amalgam – one surface, permanent	$50.00	No	Permanent Teeth – 1 – 32
D2150	amalgam – two surfaces, permanent	$59.00	No	
D2160	amalgam – three surfaces, permanent	$71.00	No	
D2161	amalgam – four or more surfaces, permanent	$81.00	No	
Resin-Based Composite Restorations:				
D2330	resin-based composite – one surface, anterior	$58.00	No	Primary tooth numbers for anterior restorations –
D2331	resin-based composite – two surfaces, anterior	$72.00	No	C – H, M – R
D2332	resin based composite – three surfaces, anterior	$83.00	No	Permanent tooth numbers for anterior restorations –
D2335	resin based composite – four or more surfaces or involving incisal-angle (anterior)	$97.00	No	6 – 11, 22 - 27
D2391	resin-based composite – one surface posterior, permanent	$59.00	No	Primary tooth numbers for posterior composite
D2392	resin-based composite – two surfaces, posterior	$75.00	No	restorations – A, B, I, J, K, L, S, T
D2393	permanent resin-based composite – three surfaces,	$87.00	No	
D2394	posterior, permanent resin-based composite – four or more surfaces, posterior, permanent	$92.00	No	

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D2391	resin-based composite – one surface posterior, permanent	$59.00	No	Permanent tooth numbers for posterior composite restorations – 1 – 5, 12 – 16, 17 – 21, 28 - 32
D2392	resin-based composite – two surfaces, posterior, permanent	$75.00	No	
D2393	resin-based composite – three surfaces, posterior permanent	$87.00	No	
D2394	resin-based composite – four or more surfaces, posterior, permanent	$97.00	No	
D2710	crown - resin – based composite (indirect)	$194.00	Yes	Submit x-rays with prior authorization request
D2720	crown - resin with high noble	$330.00	Yes	
D2721	metal crown – resin with predominantly base metal	$329.00	Yes	Covered for anterior and bicuspid teeth when conventional restoration is not possible.
D2722	crown – resin with noble metal	$329.00	Yes	
D2740	crown – porcelain/ceramic	$330.00	Yes	
D2750	substrate crown – porcelain fused to high noble metal	$330.00	Yes	Covered for molar teeth that have been endodontically treated that cannot be adequately restored with a stainless steel crown, amalgam or resin restoration
D2751	crown porcelain fused to predominantly base metal	$330.00	Yes	
D2752	crown – porcelain fused to noble metal	$330.00	Yes	
D2790	crown – full cast high noble metal	$330.00	Yes	
D2791	crown – full cast predominantly base metal	$330.00	Yes	
D2792	crown – full cast noble metal	$330.00	Yes	
Other Restorative Services:				
D2910	recement inlay, onlay, or partial coverage restoration	$20.00	No	
D2915	recement cast or prefabricated post and core	$38.00	No	
D2920	recement crown	$20.00	No	
D2930	prefabricated stainless steel crown – primary tooth	$116.00	No	
D2931	prefabricated stainless steel crown – permanent tooth	$116.00	No	
D2932	prefabricated resin crown	$103.00	No	Covered for primary anterior teeth
D2933	prefabricated stainless steel crown with resin window	$134.00	No	
D2934	prefabricated esthetic coated stainless steel crown	$134.00	No	Primary tooth
D2940	protective restoration	$32.00	No	
D2950	core buildup, including any pins	$73.00	No	
D2951	pin retention – per tooth, in addition to restoration	$11.00	No	

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D2954	prefabricated post and core in addition to crown	$94.00	No	
D2970	temporary crown (fractured tooth)	$73.00	No	
D2980	crown repair, by report	BR	No	A description of treatment provided must be submitted on or in the dental claim. This service is reviewed prior to payment.
D2999	unspecified restorative procedure, by report	BR	No	
ENDODONTICS				
D3220	therapeutic pulpotomy (excluding final restoration)	$70.00	No	Covered for primary teeth. Not covered for permanent teeth.
D3230	pulpal therapy (resorbable filling) – anterior primary tooth	$85.00	No	
D3240	(excluding final restoration) pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$90.00	No	
D3310	root canal therapy – anterior (excluding final restoration)	$243.00	No	
D3320	root canal therapy – bicuspid (excluding final restoration)	$251.00	No	Covered for permanent teeth.
D3330	root canal therapy – molar (excluding final restoration)	$334.00	No	Age 19 & older: Not covered for maxillary 2nd molar if 1st molar is in occlusion.
D3346	retreatment of previous root canal therapy – anterior	$221.00	No	
D3347	retreatment of previous root canal therapy – bicuspid	$251.00	No	
D3348	retreatment of previous root canal therapy - molar	$334.00	No	
D3351	apexification/recalcification	$88.00	No	
D3410	apicoectomy	$171.00	No	Covered on permanent anterior teeth.
D3999	unspecified endodontic procedure	$40.00	No	Covered for emergency treatment to relieve endodontic pain. Include the tooth number on the claim.

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
PERIODONTICS				
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or bonded teeth spaces per quadrant	$94.00	No	
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or bonded teeth spaces per quadrant	$71.00	No	
D4341 D4342	periodontal scaling and root planing – four or more teeth per quadrant periodontal scaling and root planing – one to three teeth per quadrant	$100.00 $52.00	Yes Yes	Submit with PA request: 1. PA x-rays 2. Perio charting 3. Health history & medical information about the client 4. Information on how long a patient in dental office.
D4355	full mouth debridement to enable comprehensive evaluation and diagnosis	$56.00	No	Covered in addition to a prophylaxis procedure. (See page 4) Clients with special needs: Cover one-D4355, (maximum of 1) and one prophylaxis procedure per-quadrant (maximum of 4) for clients that have special needs. Special need clients are clients with mental retardation, or clients that must be treated in a hospital outpatient or Ambulatory Surgical Center setting.
D4910	periodontal maintenance	$29.00	Yes	Submit with PA request: 1. Date scaling & root planing completed. 2. Health history & medical information about the client. 3. Frequency client must be seen for maintenance procedure Covered for clients that have had periodontal scaling & root planing, and are compliant with home care within their abilities. Must submit annual prior authorization request to continue billing.

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
PROSTHODONTICS (REMOVABLE): A complete prosthetic appliance case includes all materials and necessary adjustments for a period of six months following placement of the prosthesis. Tissue conditioning is covered one time during the first six months following the placement of the prosthesis. (See D5850 and D5851.) Materials used for codes D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5820 and D5821 must be of a quality that with normal wear the prosthetic appliance will last a minimum of five years.				
D5110 D5120	complete denture – maxillary complete denture - mandibular	$538.00 $538.00	Yes Yes	Covered 6 months after placement of treatment/interim denture (D5810 and D5811) or as replacement of existing denture that is no longer wearable and cannot be made wearable. Relines, rebases and adjustments are not covered for 6 months after placement of the prosthesis Submit with PA request: 1. Date of previous denture placement 2. Information on condition of existing denture.
D5130 D5140	immediate denture – maxillary immediate denture - mandibular	$538.00 $538.00	No No	Considered a permanent denture. Covered one time. Relines, rebases and adjustments are not covered for 6 months after placement of the prosthesis.

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
PARTIAL DENTURES: (Codes D5211, D5212, D5213, D5214) Covered if client does not have adequate occlusion. Adequate occlusion is defined as 1st molar to 1st molar, or a similar combination of anterior and posterior teeth on the upper or lower arch in occlusion. One to three missing anterior teeth should be replaced with a flipper partial (D5820 and D5821). *** Note: First tooth $75.00, each additional tooth $28.00				
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth) Includes acrylic resin base denture with resin or wrought wire clasps	$377.00	Yes	Submit with PA request: 1. Chart or list missing teeth. 2. Provide age of any existing partial and condition of that partial 3. X-rays of remaining teeth. Relines, rebases and adjustments are not covered for 6 months after placement of the prosthesis.
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth) Includes acrylic resin base denture or wrought wire clasps	$377.00	Yes	
D5213	maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$472.00	No	**Coverage limited to clients age 20 and younger.** Replaced one time if lost or broken. Relines, rebases and adjustments are not covered for 6 months after placement of the prosthesis.
D5214	mandibular partial denture – cast mental framework with resin denture bases (including any conventional clasps, rests and teeth)	$472.00	No	
D5410	adjust complete denture – maxillary	$20.00	No	Not covered for 6 months following placement of a new prosthesis. After 6 months covered as needed to make prosthetic appliance wearable.
D5411	adjust complete denture – mandibular	$20.00	No	
D5421	adjust partial denture – maxillary	$20.00	No	
D5422	adjust partial denture – mandibular	$20.00	No	
D5510	repair broken complete denture base	$94.00	No	Covered as needed to make existing prosthetic appliance wearable.
D5520	replace missing or broken teeth – complete denture (each tooth)	***Note	No	
D5610	repair resin denture base	$94.00	No	
D5620	repair cast framework	$108.00	No	Covered as needed to make existing prosthetic appliance wearable.
D5630	repair or replace broken clasp	$108.00	No	
D5640	replace broken teeth – per tooth	***Note	No	

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D5650	add tooth to existing partial denture	***Note	No	
D5660	add clasp to existing partial denture	$103.00	No	
D5710	rebase complete maxillary denture	$185.00	No	Not covered for 6 months following the placement of a new prosthesis.
D5711	rebase complete mandibular denture	$185.00	No	After 6 months, covered as needed to make existing prosthetic appliance wearable.
D5720	rebase maxillary partial denture	$185.00	No	Not covered for 6 months
D5721	rebase mandibular partial denture	$185.00	No	following the placement of a new prosthesis.
D5730	reline complete maxillary denture (chair side)	$94.00	No	After 6 months, covered as needed to make existing
D5731	reline complete mandibular denture (chair side)	$94.00	No	prosthetic appliance wearable.
D5740	reline maxillary partial denture (chair side)	$94.00	No	
D5741	reline mandibular partial denture (chair side)	$94.00	No	
D5750	reline complete maxillary denture (laboratory)	$156.00	No	
D5751	reline complete mandibular denture (laboratory)	$156.00	No	During the first 6 month period,
D5760	reline maxillary partial denture (laboratory)	$156.00	No	following placement of a prosthetic appliance, tissue conditioning (D5850 & D5851)
D5761	reline mandibular partial denture (laboratory)	$156.00		are covered. (See page 11 of 17).
D5810	Interim complete denture (maxillary)	$349.00	No	Can be replaced with a complete denture 6 months
D5811	Interim complete denture (mandibular)	$349.00	No	after placement of the interim denture. Complete dentures require prior authorization. (See page 8). Relines, rebases and adjustments are not covered for 6 months after placement of the prosthesis.
D5820	interim partial denture (maxillary) (flipper partial)	$236.00	Yes	Considered a permanent replacement for 1 to 3 missing anterior teeth.
D5821	interim partial denture (mandibular) (flipper partial)	$236.00	Yes	Not covered for temporary replacement of missing teeth Relines, rebases and adjustment are not covered for 6

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
				months after placement of the prosthesis. Submit with PA request: 1. Chart or list missing teeth and teeth to be extracted. 2. Age of existing partials. 3. Information on condition of existing partial.
D5850 D5851	tissue conditioning, maxillary tissue conditioning, mandibular	$43.00 $43.00	No No	Covered one time during the first 6 months following placement of prosthesis. Covered at other times with documentation of medical necessity.
D6930	re-cement fixed partial denture	$42.00	No	
ORAL AND MAXILLOFACIAL SURGERY				
D7111	extraction, coronal remnants – deciduous tooth (A – T)(Primary Teeth only)	$44.00	No	Extractions are covered when there is documented medical need in the dental chart for the extraction.
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal) (A – T) (1 – 32)(Primary and Permanent Teeth)	$59.00	No	
D7210	surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	$93.00	No	The Medicaid fee for extractions includes local anesthesia, suturing
D7220	removal of impacted tooth – soft tissue	$122.00	No	If needed, and routine postoperative care. (See 471 NAC 6-005, Page 9 of 14)
D7230	removal of impacted tooth – partially bony	$167.00	No	
D7240	removal of impacted tooth – completely bony	$202.00	No	
D7241	removal of impacted tooth – completely bony, unusual surgical complications	$212.00	No	
D7250	surgical removal of residual tooth roots (cutting procedure)	$88.00	No	

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus	$150.00	No	
D7280	surgical access of an unerupted tooth (permanent teeth only)	$140.00	No	
D7282	mobilization of erupted or malpositioned tooth to aid eruption	$114.00	No	
D7283	placement of device to facilitate eruption of impacted tooth (permanent teeth only)	$135.00	No	
D7285	biopsy of oral tissue – hard (bone, tooth)	$94.00	No	The Medicaid fee is for the professional component only.
D7286	biopsy of oral tissue – soft	$85.00	No	The lab must bill the specimen charge.
D7310	alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces per quadrant	$88.00	No	The Medicaid fee for extractions includes routine recontouring of the ridge and/or suturing as necessary.
D7311	alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$71.00	No	
D7320	alveoloplasty not in conjunction with extractions four or more teeth or tooth spaces per quadrant	$94.00	No	Alveoloplasty is a separate billable procedure.
D7321	alveoloplasty not in conjunction with extractions one to three teeth or tooth spaces, per quadrant	$76.00	No	D7310 and D7311 are covered when it is necessary beyond routine recontouring to prepare the ridge for a prosthetic appliance.
D7410	radical excision – lesion diameter up to 1.25 cm	BR	No	
D7411	excision of benign lesion greater than 1.25 cm	BR	No	
D7412	excision of benign lesion, complicated	BR	No	
D7413	excision of malignant lesion up to 1.25 cm	BR	No	
D7414	excision of malignant lesion, greater than 1.25 cm	BR	No	
D7415	excision of malignant lesion, complicated	BR	No	
D7440	excision of malignant tumor – lesion diameter up to1.25 cm	BR	No	

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D7441	excision of malignant tumor – lesion diameter greater than 1.25 cm	BR	No	
D7450	removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	BR	No	
D7451	removal of benign odontogenic cyst or tumor – lesion diam. greater than 1.25 cm	BR	No	
D7460	removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	BR	No	
D7461	removal of benign nonodontogenic cyst or tumor – lesion diam. greater than 1.25 cm	BR	No	
D7465	destruction of lesion(s) by physical or chemical method, by report	BR	No	
D7471	removal of lateral exostosis (maxilla or mandible)	$110.00	No	
D7510	incision and drainage of abscess – intraoral soft tissue	$42.00	No	
D7880	occlusal orthotic device, by report	BR	No	Occlusal orthotic devices are defined as splints that are provided for treatment of temporomandibular joint dysfunction. The fee includes any necessary adjustments. Document the type of appliance made and medical condition on or in the claim. For treatment of bruxism or for minor occlusal problems, see D9940. (See page 17 of 17).
D7960	frenulectomy (frenectomy or frenotomy) – separate procedure	$92.00	No	

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
ORTHODONTICS: Orthodontic treatment is covered for clients age 20 and younger when determined to have a handicapping malocclusion by a Medicaid Dental Consultant. Orthodontic codes restricted to age 20 and younger are D8060 – D8999.				
D8060	interceptive orthodontic treatment of the transitional dentition	Fee determined by treatment	Yes	See 471 NAC 6-005 page 11 of 14 and page 12 of 14 for coverage criteria for orthodontic treatment
	Procedures covered under code D8060			
	• Chrome steel wire clasps-each .036 or minimum .030	$21.00	Yes	
	• inclined plane (hawley) appliance, bite plane, with clasps	$156.00	Yes	
	• cross-bite appliance, anterior, acrylic	$129.00	Yes	
	• cross-bite appliance, posterior, two bands plus attachments	$129.00	Yes	
	• attachment springs for any orthodontic or pedodontic appliance - each	$21.00	Yes	
	• adjustment of pedodontic and interceptive orthodontic appliances (allowed one per month)	$17.00	Yes	
	• space maintainer – fixed – unilateral, part of interceptive orthodontic treatment plan	$110.00	Yes	
	• space maintainer – fixed – bilateral, part of interceptive orthodontic treatment plan	$190.00	Yes	
D8090	Comprehensive orthodontic treatment of the adult dentition	Fee determined by treatment plan	Yes	See 471 NAC 6-005 page 11 of 14 and page 12 of 14 for coverage criteria for orthodontic treatment.
	Procedures covered under code D8090:			
	• constructing and placing fixed maxillary appliance, active treatment	$350.00	Yes	

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
	• constructing and placing fixed mandibular appliance, active treatment	$350.00	Yes	
	• each one month period of active treatment – maxillary arch	$35.00	Yes	
	• each one month period of active treatment – maxillary arch, unusual service (surgical correction case)	$51.00	Yes	
	• each one month period of active treatment – mandibular arch	$35.00	Yes	
	• each one month period of active treatment – mandibular arch, unusual service (surgical correction case)	$51.00	Yes	
	• retainer or retention appliance	$95.00	Yes	
	• each one-month period of retention appliance			
	• treatment, maxillary arch	$19.00	Yes	
	• each one-month period of retention appliance treatment, mandibular arch	$19.00	Yes	
	• rapid palatal expander (RPE) or cross-bite correcting (fixed) appliance	$178.00	Yes	(Comprehensive orthodontic treatment continued.)
	• herbst appliance	$270.00	Yes	
	• protraction facemask	$162.00	Yes	
	• slow expansion appliance	$177.00	Yes	
	• headgear	$162.00	Yes	
	• inclined plane (hawley) appliance, bite plane, with clasps	$156.00	Yes	
	• orthodontic appliance not listed	BR	Yes	
	• orthodontic procedure not listed	BR	Yes	
	• space maintainer – fixed – unilateral, part of comprehensive orthodontic treatment plan	$110.00	Yes	
	• space maintainer – fixed – bilateral, part of comprehensive orthodontic treatment plan	$190.00	Yes	

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D8210	removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)	$150.00	No	
D8220	fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	$206.00	No	
D8691	repair of orthodontic appliance	BR	No	Include a description of the repair on or in the claim.
D8692	replacement of lost or broken retainer	$95.00	No	Covered if the client is compliant with wearing the appliance.
D8999	unspecified orthodontic procedure, by report	BR	No	Billable for repairs associated with orthodontic treatment when repairs exceed routine repairs associated with orthodontic treatment. Include a description of the repair on or in the claim.

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
ADJUNCTIVE GENERAL SERVICES:				
D9110	palliative (emergency) treatment of dental pain – minor procedure	$23.00	No	Examples: treatment of soft tissue infections, smoothing a fractured tooth. Include a description of the treatment on or in the claim.
D9220	general anesthesia – first 30 minutes	$162.00	No	Covered when it is medically necessary to treat the client.
D9221	general anesthesia – each additional 15 minutes	$81.00	No	
D9230	analgesia, anxiolysis, inhalation of nitrous oxide	$22.00	No	
D9241	intravenous conscious sedation/analgesia – first 30 minutes	$94.00	No	Document the medical need in the dental chart.
D9242	intravenous conscious sedation/analgesia - each additional 15 minutes	$43.00	No	
D9248	non-intravenous conscious sedation	$150.00	No	
D9410	house/extended care facility	$35.00	No	Cover one per day per facility
D9420	hospital call	$80.00	No	regardless of the number of patients seen. Document on or in the claim the name of the facility, or home address where treatment was provided.
D9440	office visit – after regularly scheduled hours	$45.00	No	Covered in addition to exam and treatment provided when treatment is provided after dental office normal office hours.
D9940	occlusal guard, by report	$164.00	No	Covered to minimize the effects of bruxism and other occlusal factors. Occlusal guards are defined as removable appliances. Document the medical need in the dental chart.